CHAMPVA POLICY MANUAL

CHAPTER: 2
SECTION: 10.6
TITLE: OPHTHALMOLOGICAL SERVICES

AUTHORITY: 38 CFR 17.270(a) and 17.272(a)(40), (41)

RELATED AUTHORITY: 32 CFR 199.4(c)(2)(xvi), (e)(6), and (g)(50)

I. EFFECTIVE DATE

October 1, 1984

II. PROCEDURE CODE(S)

A. CPT codes: 65091-68899, 76511-76536, 92002-92060, 92070-92140, 92225-92235, 92240-92287, and 99201-99275

B. HCPCS Level II codes: V2627

III. DESCRIPTION

A. Ophthalmological services may include an examination and other specialized services necessary to diagnose and/or treat a medical condition of the eye and associated structures.

B. A routine eye examination is an evaluation of the eyes, including but not limited to refractive services. A routine eye examination is not related to a medical or surgical condition or to the treatment of an illness or injury.

IV. POLICY

Medically necessary ophthalmological services (including refractive services) provided in connection with the medical or surgical treatment of a covered illness or injury may be cost shared. Medical documentation is required from the physician supporting the specialized ophthalmological services. Coverage of ophthalmological services is dependent on the purpose of the examination rather than on the ultimate diagnosis of the patient's condition. For example, when a beneficiary goes to or is referred to an ophthalmologist with a complaint or symptoms of an eye disease or injury, the ophthalmologist's services (except for eye refractions) are covered regardless of the fact that only eyeglasses were prescribed. However, when a beneficiary goes to his/her ophthalmologist for an eye examination with no specific complaint, the expenses for the examination are not covered even though as a result of such examination a pathologic condition was discovered.

V. POLICY CONSIDERATIONS

A. The Health Administration Center (HAC) will follow the coding guidelines described in the Physician Current Procedural Terminology (CPT) book, published by the American Medical Association and HCPCS Level II Codes.

B. Reimbursement will be made for ophthalmology services (including refractive services) performed in the evaluation of an eye disease associated with diabetes, glaucoma, cataracts, or post surgical prosthetic lenses (see Chapter 2, Section 10.2, *Eye and Ocular Adnexa)*.

C. If the sole purpose of an examination is the performance of any of the specialized services (CPT 92015-92060, 92070-92287), a medical office visit (CPT 92002-92014, 99201-99275) should not be billed in addition to the specialized services.

D. According to CPT, the following procedure codes represent unilateral services: CPT 92225-92235, 76511-76514. If any of these diagnostic services are performed bilaterally (two procedures), CHAMPVA bases reimbursement on the CHAMPVA Maximum Allowable Charge (CMAC) for each of the procedures.

VI. EXCLUSIONS

A. Routine eye examinations performed for the purpose of prescribing, fitting or changing eyeglasses (all refractions), are not covered benefits. The CPT codes routinely used in the submission for payment for routine eye examinations are:

92002 - Eye exam, new patient;

92004 - Eye exam, new patient;

92012 - Eye exam, established patient;

92014 - Eye exam and treatment;

99172 - Ocular function screen; and

99173 - Visual acuity screen

B. The following diagnostic codes are often used to identify a routine examination: ICD-9 codes V72.0; 360.21; 367.0; 367.1; 367.2; 367.20; 367.21; 367.22; 367.3; 367.31; 367.32; 367.4; 367.51; 367.52; 367.53; 367.9; and 368.13.

C. Orthoptic and/or pleoptic training. [38 CFR 17.272(a)(40]

END OF POLICY